



State Coroners Office
57-83 Kavanagh Street
Southbank 3006
Telephone: (03) 9684 4444
(All Hours)
Toll Free: 1800 136 852
(Only Country Victoria)
Fax: (03) 9682 1206

Coroner's "Investigation Standard": Fall-related deaths in hospital

Introduction

The investigation standard is applicable to falls in all Victorian hospitals (public and private). The investigation commences on return of a preliminary cause of death from a pathologist indicating that a fall is either the direct or contributing cause of the death. Medical records will be obtained and reviewed by the Clinical Liaison Service at the State Coroner's Office (for any issues additional to the fall/s).

Details to be provided to the State Coroner

1. A list from the hospital of all staff involved in:
 - Initially assessing or reviewing the patient for falls risk
 - The actual fall incident(s) and the events leading to the fall
 - Who have knowledge of the incident
2. The Incident report (if completed)
3. Risk screening policy and protocol documents and/or procedure manuals
4. Falls prevention policy and protocol documents and/or procedure manuals
5. Falls management policy and protocol documents and/or procedure manuals
6. Additional material will be required setting out:
 - When the policy or procedure documents were last reviewed (a copy of any earlier documents will be required);
 - Documentation explaining how the policy and protocol documents and/or procedure manuals were developed, by whom and the sources of information used.

If as a result of the incident under investigation by the Coroner, there have been changes to the hospital's policies or procedures, please forward the details of the changes and how they occurred. (I.e. how was the new policy or procedure developed and what additional information was sought from other agencies/hospitals as to the preferable countermeasures to be adopted to address the perceived problem).

Specific questions to be answered

1. Patient history

- a) What is the patient's past medical history? (Please include co-morbidities, current medications and reasons for hospital admission).

2. The event and events leading up to the fall

- a) What happened immediately before and after the fall?
- b) How many falls or near falls did the deceased have in the past twelve months?
- c) Had the deceased previously suffered any major injury from a fall?
- d) Had the deceased undergone a risk screening assessment about the risk of falling in this facility? If so what action resulted from the assessment?
- e) How often was the patient re-assessed or the falls management plan reviewed and checked?
- f) What were the circumstances surrounding the fall immediately prior to death?
- g) What external factors were present? For example:
 - Cot-sides (used or not-used?)
 - Fixed legs or wheels (If wheels, were they locked or unlocked?)
 - State of floor surface (slippery, uneven?)
 - Lighting
 - Staff/carer supervision
 - Other
- h) Was there a detailed incident report form or similar completed? Is there any information regarding the fall that is recorded other than in the incident form or medical record?

3. The facility's system for falls management

- a) What were the facility's policy, protocol and practice regarding risk screening for falls at the time of the incident?
- b) What are the facility's policy, protocol and practice regarding falls prevention strategies?
- c) What are the facility's policies, protocols and practices regarding falls management after a fall has occurred.
- d) What previous initiatives, if any, has the facility undertaken in the last 2 years regarding risk screening for falls and falls prevention and management of clients following a fall?

4. Relevant equipment or work practice

If equipment or a particular work practice was involved in the fall (ie wheel chair, low-line beds, walking frame, cot-sides):

- a) Has the operation of that equipment / work practice been reviewed to see whether any improvement can be made? If so, has the product manufacturer or some other expert been required to assist with the review?
- b) If a particular product was involved, were the manufacturer's instructions available and followed? (If not why not?).
- c) If a particular work practice was involved, how often has that practice (or part thereof) been reviewed? Is this practice commonly used across the hospital sector?